PANDEMIC INFLUENZA PREPAREDNESS PLAN

I. PURPOSE

The purpose of the District of Columbia Pandemic Influenza Preparedness Plan is to reduce morbidity and mortality and to minimize social and economic disruption due influenza pandemic.

II. PLANNING ASSUMPTIONS

- Influenza pandemics are inevitable but unpredictable. Outbreaks are expected to occur simultaneously throughout much of the United States.

- An influenza pandemic will severely tax and perhaps overwhelm healthcare resources at the local, regional and federal levels, requiring extraordinary measures to contain the outbreak and provide medical care to victims of the disease.

- The District must prepare to rely on its own resources to respond to a pandemic.

- It is likely that an influenza pandemic will require the mobilization of all District Government Employees (as Essential Employees) in order to respond effectively.

- The District Response Plan (DRP) is the overarching organizational structure for all emergency responses in the District, addressing all phases of emergency management. The DRP serves to unify and coordinate the response efforts of all District agencies.

- A Mayoral Declaration of a Public Health Emergency and implementation of isolation and/or quarantine procedures may be implemented to control the spread of the disease.

- Effective response to the influenza pandemic will require the coordinated efforts of our public, private, federal and business partners throughout the NCR.

- The District of Columbia Department of Health policies and procedures for surveillance, treatment and disease control and recovery will be closely aligned with the guidelines from the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO).

- The effect of the influenza pandemic on individual wards and communities may be relatively prolonged (months) in comparison to other types of disasters.

- Health care workers and other first responders will be at higher risk of exposure and illness than the general population due their close contact with infected persons.

- Critical personnel shortages (public health workers, healthcare providers, police, firemen, utility workers, transportation workers, military personnel) due to illness, family or personal responsibilities are estimated to be at least 30%.

- Effective prevention and therapeutic measures (vaccine and antiviral medications) may be in short supply.

- Delayed and/or limited vaccine supplies will require development of a system of prioritization to ensure that the vaccines are distributed appropriately.

- There may be critical shortages of healthcare resources including but not limited to staffed hospital beds, mechanical ventilators, morgue capacity, and temporary holding sites with refrigeration for storage of bodies.

- Distribution of timely and appropriate critical information to healthcare providers, other partners and the public is essential for effective response and disease control.

- Enhanced syndromic surveillance, increased Public Health Laboratory testing and clinician reporting will likely lead to early identification of a novel (pandemic) influenza virus in the District.

- The resumption of normal public health and other healthcare functions is critical to the successful recovery of the District's social and economic infrastructure.

III. LEGAL AUTHORITY

The Preventive Health Services Amendment Act of 1985 (D.C. Official Code § 7-131 *et seq.*) authorizes the Mayor, in consultation with the Director of the Department of Health, to control the spread of a communicable disease, including the authority to order examination, treatment, isolation, or quarantine of a person or persons. The District of Columbia Public Emergency Act of 1980 (D.C. Official Code § 7-2301 *et seq.*) authorizes the Mayor to declare a public emergency and a public health emergency and take whatever measures are necessary to abate the conditions that cause the emergency. Chapter 2 of Title 22 of the District of Columbia Municipal Regulations (DCMR) grants the Director of

the Department of Health authority, independent of the Mayor, to take action to prevent the spread of a communicable disease, provided the Director is taking action pursuant to a report of a communicable disease from a health care provider. Action the Director takes pursuant to the DCMR uses the same due process procedures included in the Preventive Health Services Amendment Act.

Sections of the D.C. Code and other authorities are described in Section Three of the core Pandemic Influenza Plan and in Appendix B of the DRP.

IV. CONCEPT OF OPERATIONS

The District Response Plan (DRP) is the overarching organizational structure for all emergency responses in the District, addressing all phases of emergency management. The DRP serves to unify and coordinate the response efforts of all District agencies.

The District's Emergency Management Agency (DCEMA) serves as the principle coordinating agency for all of the city's response, recovery and mitigation activities. The Director will be appointed by the Mayor as the D.C. Coordinating Officer to represent the District in operational relationships with the Department of Homeland Security.

The District of Columbia Department of Health is the Primary District Agency for ESF#8, Health and Medical Services, and is responsible for ensuring the adequate provision of public health and medical care needs during a public emergency.

- COMMAND AND CONTROL

The Director of the Department of Health (DOH) will serve as the Incident Commander of the Public Health Response. The DOH Incident Command System (ICS) will be implemented under the DRP utilizing NIMS guidelines.

- SURVEILLANCE

The Influenza season begins in October and ends in May of the following year. Influenza-like Illness (ILI) and Influenza cases are reported to the Department of Health on a weekly basis through hospital surveillance, syndromic surveillance, laboratory testing and sentinel surveillance. ILI is defined as a fever ($\geq 100^{o}$F) and cough and/or sore throat in the absence of a known cause. Influenza cases are confirmed through laboratory testing.

Hospital Surveillance:

The nine (9) District hospitals submit reportable disease forms (or electronic information) containing detailed information on all influenza cases admitted through the emergency department (ED) for ILI or influenza on a weekly basis. This information is compiled weekly and used to establish the influenza incidence rate for the District of Columbia.

Sentinel Surveillance:

The District of Columbia participates in the CDC's nation-wide influenza surveillance program, Influenza Sentinel Surveillance. Sentinel surveillance for ILI and influenza consist of 2 sentinel reporting physicians for the District (1 physician/250,000 population according to CDC guidelines) and a network of 18 additional, voluntary sites consisting of daycare centers, some hospital laboratories, college health units, and long-term care facilities throughout the District of Columbia. The sentinel surveillance sites report only the total number of ILI and Influenza cases encountered per week, not detailed surveillance information. Influenza activity can be characterized, according to CDC guidelines, as *no activity*, *sporadic*, *local*, *regional*, and *widespread*.

Syndromic Surveillance:

The nine (9) District hospitals submit intake information on all patients admitted through the emergency department (ED) on a daily basis. The patient's chief complaint or symptom is used to catalog the patient's visit into one of eight syndrome categories (death, sepsis, rash, respiratory, gastro, unspecified infection, neurological, and other). If the daily percentage of ED visits for a syndrome is significantly higher than the syndrome's 7-day average percentage of ED visits, an alert is raised indicating unusual disease activity may be occurring.

For ILI and influenza surveillance using syndromes, hospital ED chief complaints identified as "respiratory illness" (RI) or "unspecified infection" (UI) are specifically monitored since these two syndromes best reflect ILI or influenza symptoms and occurrence. These combined RI and UI percentages are plotted, for comparison, against the percentage of RI and UI visits made to hospital emergency departments for the four previous influenza seasons in an effort to capture unusual influenza activity.

Public Health Lab Surveillance:

Laboratory detection will depend upon the submission of influenza-like illness specimens from our sentinel hospitals and clinics. The laboratory will actively distinguish between the various flu strains using the following algorithm.

Influenza Type A or B. If type A, sequential subtyping (H1, H3, H5, H7) will be conducted by RT-PCR. All H5 or H7 specimens will be sent to CDC for further characterization.

- VACCINATIONS

Vaccination is the primary control measure to prevent influenza. Because a shortage of vaccine is anticipated early in the pandemic, prioritization of the persons receiving the initial doses of vaccine will be necessary. When vaccine does become available, the demand will exceed the supply for some time. Although the overarching goal will be to vaccinate the entire District population, this will have to be accomplished in stages. Priority groups will be identified in advance of a pandemic so that the vaccine can be administered in a way that minimizes morbidity and mortality from the pandemic influenza strain, and reduces its impact on our community. Mass vaccinations will be managed according to the District's Strategic National Stockpile (SNS) Plan.

- ANTIVIRAL MEDICATIONS

Antiviral drugs for influenza are an adjunct to influenza vaccine for controlling and preventing influenza. These medications are not a substitute for vaccination. Supplies of the antiviral drugs are limited. Antiviral drugs have been added to the Strategic National Stockpile and would be distributed according to the District's SNS Plan.

- MEDICAL SURGE

The District of Columbia strategy for health and medical surge capacity uses a modular approach to build on existing capability as needs grow. The District's EMS system, clinics, and hospital communities have been engaged in assessing and building capability. However, additional sectors outside those communities (private physicians, nursing homes, voluntary organizations) are necessary to add vital capacity to our public health response system.

- COMMUNICATIONS

The goal of the District's Communication Plan is to distribute timely, accurate, consistent and easily understood information to healthcare providers and the

public. The dissemination of timely and accurate information is essential to maintaining order, minimizing public fear and misperceptions and facilitating public protection. All communications regarding the pandemic will be coordinated through the Joint Information Center as described in the DRP.

- REGIONAL/FEDERAL COORDINATION

  Regional/federal coordination of all pandemic influenza planning and response activities will help to ensure the optimal flow of accurate information and maximal utilization of resources to control the spread of the disease and facilitate mitigation and recovery.